# SACRAMENTO COUNTY HEALTH AUTHORITY COMMISSION

## General Meeting

February 19, 2026, 3:00 PM

# Agenda Item 1: Welcome/Opening Remarks & Updates

# Agenda Review

1. Welcome/Opening Remarks and Updates
2. Action: Approval of 12/2/25 Meeting Minutes & Revised 2026 SCHA General Meeting Calendar
3. Discussion & Action: Nominate and Approve SCHA Vice-Chair
4. Action: Update QIQA and CPC Member Appointments
5. Presentation and Discussion: State & Federal Budget and Policy Updates Related to Medi-Cal
6. Discussion and Actions: Medi-Cal Dental Advisory Committee Letter and CalAIM 1115 Waiver Renewal
7. Presentation, Discussion and Action: Approach to Measuring Access to Specialty Care and Data Request
8. Public Comment
9. Closing Comments and Adjournment

# Agenda Item 2: Approval of Meeting Minutes & Revised 2026 SCHA General Meeting Calendar

# Agenda Item 3: Nominate and Approve SCHA Vice-Chair

# Agenda Item 4: Update QIQA and CPC Member Appointments

# Committee Appointments

- **QIQA**
  - Britta Guerrero
  - Cortney Maslyn
  - Dr. Ravinder Khaira
  - Eddie Kirby
  - Margarita Dodatko
  - Michelle Monroe

- **CPC**
  - Dr. Kirti Malhotra (Chair)
  - Eddie Kirby
  - Kim Williams
  - Margarita Dodatko
  - Nicholas Capistrano

# Agenda Item 5: State and Federal Budget and Policy Updates Related to Medi-Cal

# State Budget Update

# Overview of Key State Budget Deadlines

- **January 10th:** Governor must submit budget for the upcoming fiscal year on or before this date
- **February 1st:** Administration must submit trailer bill proposals on or before this date
- **April:** Finance budget letters released for technical budget adjustments
- **May 14th:** Governor must release the May Revision on or before this date
- **June 15th:** Legislature must pass a balanced budget by this date
- **July 1:** State fiscal year begins

**Throughout the Spring, the Legislature reviews the Governor's proposed budget and holds budget hearings**

# Major Medi-Cal 2025 Budget Actions

Immigrant coverage related actions:

- Enrollment freeze for full-scope, state-only Medi-Cal for adults 19 and older who are undocumented, effective January 1, 2026
- Premiums of $30 for state-only Medi-Cal for adults 19-59 with Unsatisfactory Immigration Status (UIS)*, effective July 1, 2027
- Elimination of state-only Prospective Payment System rates for certain health clinics for UIS members, effective July 1, 2026
- Elimination of dental benefits for UIS adults ages 19 and older, effective July 1, 2026

*UIS includes individuals who are undocumented as well as certain legal non-citizens

# Major Medi-Cal 2025 Budget Actions Cont.

Other major actions:

- Reinstatement of Medi-Cal asset test limit
- Elimination of $362 million Proposition 56 supplemental dental payments in 2026-27 and ongoing
- Various pharmacy related changes including step therapy, utilization management and prior authorization, and elimination of coverage of certain drugs

# Overall Budget Summary

- On January 9th, Governor released his 2026-27 proposed budget
- Projects an approximately **$3 billion budget deficit**
- To close the gap, the budget includes various spending solutions that include Medi-Cal
- $343.6 billion ($94.4 billion General Fund) proposed spending for health and human services programs in 2026-27
- **Medi-Cal is one of the largest drivers of increased cost**
- **Incorporates impacts of federal H.R. 1** for health and human services programs — about $1.1 billion GF costs are in Medi-Cal in 2026-27

# Budget and Economic Outlook

- While the Governor projects a shortfall of about $3 billion, the Legislative Analyst's Office (LAO) estimates a **much larger gap of roughly $18 billion**
- Revenue gains fueled by AI companies and related stock market increases
- Large out year budget shortfalls projected of **roughly $20 billion to $35 billion annually**
- **Deficits are structural**

- Major budget risks due to:
  - Potential stock market decline – most significant
  - Uncertain and changing federal policies

# Medi-Cal Overview

- Department of Health Care Services (DHCS) Medi-Cal budget for local assistance includes **$222.4 billion total funds* ($48.8 billion GF) in 2026-27**, an increase of $25.7 billion, or roughly 13 percent, over current-year estimates
- Medi-Cal is projected to cover about **14 million members in 2026-27, a 3.5 percent decline,** compared to revised 2025-26 estimates
- **Assumes impacts from H.R. 1** requirements related to eligibility, financing, and immigrant coverage restrictions

*Excludes DHCS state operations, certain local government expenditures, and GF expenditures budgeted in other state departments for Medi-Cal programs

Source: 2026-27 Governor's Budget, Department of Health Care Service Highlights, January 9, 2026

# H.R.1 Implementation: Medi-Cal

Budget year impacts include:

- **Federal Match Reduction for Emergency Services** for Affordable Care Act (ACA) adult expansion individuals with UIS from 90 to 50 percent effective October 1, 2026, resulting in $658 million in state GF costs
- **Implement Work and Community Engagement Requirements** for ACA adult expansion individuals effective January 1, 2027, resulting in savings of $373.3 million total funds
- **ACA Adult Expansion Six-Month Redetermination** requirements effective January 1, 2027, resulting in cost reduction of $463.3 million total funds
- **Retroactive Medi-Cal Eligibility for ACA Adult Expansion** to one-month effective January 1, 2027, resulting in budget savings of $23 million total funds

# H.R.1 Implementation: Medi-Cal Cont.

Additional budget year adjustments include:

- **County Administration** impacts due to eligibility changes — state is working with counties to determine needed support
- **Hospital Quality Assurance Fee and Managed Care Tax (MCO)** related impacts

# H.R.1 Implementation: Related Discretionary Proposals

1. **Extending eligibility requirements related to work and community engagement** to certain immigrant groups that receive state-only funded Medi-Cal coverage
2. **Transitioning certain legal non-citizen immigrants* from full scope to restricted scope Medi-Cal** effective October 1, 2026, due to eligibility changes that eliminate federal funding assistance for this population
   - Impacts an estimated 200,000 individuals
   - If the state were to provide full Medi-Cal coverage to this population, the Administration projects costs to be about $786 million GF in 2026-27 and $1.1 billion GF ongoing

* Includes asylees, victims of human trafficking, most refugees, and others

# H.R. 1 Implementation: Rural Health Transformation Program (RHTP)

- Federal program established by H.R. 1 providing $50 billion to eligible states over 5 years
- Budget assumes $233.6 million in federal funds awarded to California for 2026 to be administered by the Department of Health Care Access and Information (HCAI)
- Approved proposal includes three initiatives:
  - Transformative care model
  - Workforce development
  - Technology and Tools

# Early Budget Action: Reproductive Health Grant

- Effective July 4, 2024, H.R. 1 restricts Medicaid participation by providers of abortion services for one-year
- Governor proposed $60 million in one-time GF support for reproductive health grants in 2025-26 for providers including Planned Parenthood to address federal funding losses
- Legislature came to budget agreement to provide $90 million GF in 2025-26 to family planning providers in response to the Governor's proposal
- SB 106 (Chapter 4, Statutes of 2026) includes this appropriation and was signed by the Governor on 2/11/26

# Managed Care Organization (MCO) Tax

- MCO tax providers significant funding to support the non-federal share of cost for Medi-Cal; remains in effect through December 31, 2026
- MCO tax has generated over $7 billion in net revenue for the state to spend annually
- No proposal for a new tax
- DHCS proposes to move forward with investments that were outlined in the May MCO tax spending plan for CY 2025 with some proposed changes

# MCO Tax: CY 2025 Spending Plan

| Domain ($ Millions) | Annual Allocation | Payment Methodologies |
|---|---|---|
| General Support of Medi-Cal Program | $2,000 | • $2,000 – General Support |
| Primary Care | $691 | • $215 – TRI<br>• $476* – MCBRI |
| Specialty Care | $575 | • $134 – TRI<br>• $353* – MCBRI |
| Community and Outpatient Procedures | $245 | • $245* – MCBRI |
| Reproductive Health | $90 | • $90 – HCAI |
| Services and Supports for Primary Care | $50 | • $50 – CCDP |

*DHCS currently recalibrating these amounts
TRI is Targeted Rate Increate; MCBRI is Managed Care Base Rate Increase; HCAI is Health Care Access and Information; CCDP is Community Clinic Directed Payment; SDP is State Directed Payment; UDI is Uniform Dollar Increase

Source: DHCS Protect Access to Health Care Act Stakeholder Advisory Committee Meeting, January 14, 2026

# MCO Tax: CY 2025 Spending Plan Cont.

| Domain ($ Millions) | Annual Allocation | Payment Methodologies |
|---|---|---|
| Emergency Department Facilities and Physicians | $355 | • $7 – TRI ED Physician Services<br>• $93 – UDI ED Physician Services<br>• $255 – Hospital SDPs/MCBRI |
| Designated Public Hospitals | $150 | • $150 – Hospital SDPs |
| Ground Emergency Medical Transportation | $50 | • $27* – MCBRI<br>• $23 – UDI |
| Behavioral Health Facility Throughputs | $300 | • $300 – Various Investments |
| Graduate Medi-Cal Education | $75 | • $75 – University of California |
| Medi-Cal Workforce | $75 | • $75 – HCAI |
| Total | $4,656 | |

*DHCS currently recalibrating these amounts

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| Domain ($ Millions) | Annual Allocation | Payment Methodologies |
|---|---|---|
| General Support of Medi-Cal Program | $2,000 | • $2,000 – General Support |
| Primary Care | $691 | • $226 – TRI<br>• $117* – MCBRI<br>• $348* UDI |
| Specialty Care | $575 | • $141 – TRI<br>• $63* – MCBRI<br>• $371* – UDI |
| Community and Outpatient Procedures | $245 | • $245 – MCBRI |
| Reproductive Health | $90 | • $90 – HCAI |
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Source: DHCS Protect Access to Health Care Act Stakeholder Advisory Committee Meeting, January 14, 2026

# Behavioral Health Proposals

- **Convert Community-Based Mobile Crisis benefit** to an optional benefit beginning April 1, 2027
- **Swapping $150 million in Proposition 1 Behavioral Health Services Act (BHSA)** funding in-lieu of state GF for workforce and prevention programs
- **Changes to MCO tax plans** for the Behavioral Health Facility Throughputs* to now cover certain non-federal share of costs for:
  - Transitional Rent
  - Community-Based Mobile Crisis Services
  - Behavioral Health Rate Increases

*The May spending plan proposed to allocate MCO tax revenues in CY 2025 for BH Facility Throughputs to support flexible housing subsidy pools and data sharing, consent management, and care coordination among behavioral health providers

# In-Home Supportive Services Proposals

- **Conforming the IHSS Residual Program** to timing of Medi-Cal coverage resulting in approximately $84 million in GF savings beginning in 2026-27
- **Eliminating the IHSS Backup Provider System** resulting in about $3.5 million in GF savings beginning in 2026-27
- **Removing State's Share of Cost from IHSS Growth in Assessed Hours** resulting in approximately $233.6 million in GF savings beginning in 2027-28

# DHCS H.R. 1 Implementation Plan

# DHCS H.R.1 Implementation Plan

- On January 29th, DHCS published its Implementation Plan for New Federal Eligibility and Enrollment Changes Under H.R. 1
- Outlines DHCS' approach to implementing federal eligibility and enrollment changes
- Key Elements:
  - Automate to protect coverage
  - Communicate with clarity and connection
  - Simplify the renewal experience
  - Educate and train those who serve Medi-Cal members
  - Provide timely and transparent communication

# Agenda Item 6: Medi-Cal Dental Advisory Committee Letter and Feedback on the State's CalAIM 1115 Waiver Renewal

# CalAIM 1115 Waiver Renewal

# CalAIM 1115 Waiver Renewal Application

- On February 10th, DHCS released its five-year CalAIM 1115 waiver renewal application — **comments due to the state no later than March 12, 2026**
- Waiver would cover period beginning January 1, 2027, through December 31, 2031
- Public hearings:
  - February 25th from 1:55- 2:55pm
  - March 3rd from 11:30-12:30pm
  - Registration links can be found on the CalAIM 1115 & 1915(b) Waiver webpage
- DHCS will submit to federal government later in 2026

# CalAIM 1115 Waiver Renewal: Overview

Objectives and goals:

1. Strengthen ability of the State, MCPs, and providers to identify and intervene early to manage member risk
2. Continue towards a more consistent and seamless system
3. Improve quality and drive delivery system transformation and innovation through value-based initiatives

Updates include the following:

- Continues several programs without changes
- Modifies several existing program authorities
- Requests authority for two new benefits
- Discontinues and/or transitions several initiatives

# Continued Program Authorities with No Modifications

- Reentry Services for Justice-Involved Populations 90-Days Pre-Release
- Drug Medi-Cal-Organized Delivery System (DMC-ODS) Institutions for Mental Disease (IMD) Exclusion for Substance Use Disorder (SUD) Services
- Chiropractic Services from Indian Health Services (IHS) and Tribal Facilities
- Align Dually Eligible Enrollees' Medi-Cal Managed Care Plan and Medicare Advantage Plan
- Managed Care Plan Authority to Limit Plan Choice in Certain Counties
- Coverage for Out-of-State Former Foster Care Youth
- Traditional Healers and Natural Helpers

# Substance Use Disorder (SUD) Services Options

- Requests to allow optional outpatient SUD services under Drug Medi-Cal (DMC) that are currently limited to the Drug Medi-Cal Organized Delivery System (DMC-ODS):
  - **Care Coordination**
  - **Recover services**
  - **Withdrawal management**
  - **Partial hospitalization**
- DHCS is also seeking new authority for DMC counties to opt-in to cover **mobile crisis services**
- Continues **peer supports** in specialty mental health services and DMC or DMC-ODS delivery systems services

# Modifications and New Program Features

## Modified Program

- **Global Payment Program (GPP)** – to add new GPP services, risk to earning GPP funding, and create separate sub-pool for system transformation investments
- **Asset Limit Test for Deemed Supplemental Security Income (SSI) Populations** – proposal to reinstate to align with state budget actions

## New Program Features

- **Employment Supports.** In the context of new federal work requirements for the adult expansion population, DHCS' proposal would seek approval to establish employment supports as a *county optional benefit* as well as funding for start-up activities.
- **BridgeCare Pilots**. A set of home-and community-based services (HCBS) and caregiver supports as a *county option* to "near duals"

# Discontinued and Transitioning Initiatives

- **Recuperative care and short-term post hospitalization housing** waiver authorities will sunset and instead DHCS proposes to:
  - Transition recuperative care to an in-lieu of service (ILOS) authority
  - Create a model for recuperative care that incorporates the levels of care offered under both services
  - Modify as needed because room and board cannon be covered under other authorities
- **Community Based Adult Services (CBAS)** to transition to a permanent 1915(i) state plan benefit authority

# Discontinued and Transitioning Initiatives Cont.

- **Providing Access and Transforming Health (PATH) Initiative**, as it was intended to be one-time support under CalAIM, will be discontinued
- **Designated State Health Program (DSHP)** financing authority will be discontinued due to federal policy to no longer approve DSHPs and PATH Initiative sunset
- **Low-Income Pregnant Women** – benefit has already transitioned to the Medi-Cal state plan benefit

# Agenda Item 7: Approach to Measuring Access to Specialty Care and Data Request

# Notes on Sacramento County Specialty Network Adequacy

Presented by Michelle Monroe, CEO
One Community Health
February 19, 2026

# How can we better understand and measure network adequacy?

# What is Sacramento's specialist capacity and demand?

# Notes from 1 FQHC's perspective...

# What we have been thinking about…

1. Sacramento residents are dying at an earlier age than CA average – is there a role for the Health Authority to intersect with Public Health?
2. The MediCal Specialty network has been insufficient for years, the nuances of the patient experience are not adequately measured
3. Our patients are demanding we do better, and rightfully so
4. With upcoming MediCal changes and uninsured rates to rise, Sacramento's health outcomes will get worse

# Sacramento County Death Rates

- A measure of the healthcare delivery system

## Sacramento County

- Ranks 33 out of 58 counties in overall age-adjusted mortality rates
- Ranks 50 out of 58 counties in cancer deaths

County Health Status Profile 2024, CHSP 2024 Tables 1-29
Health Status Assessment 2020, Sac County Public Health

**Table 4: Age-Adjusted Death Rates per 100,000, Over Time**

| | RY 2024 (CY 2020-22) | RY 2023 (CY 2019-2021) | RY 2022 (CY 2018-2020) | RY 2021 (CY 2017-2019) | RY 2020 (CY 2016-2018) |
|---|---|---|---|---|---|
| Sacramento County | 785.2 | 763.4 | 744.6 | 710.5 | 735.7 |
| California | 670.0 | 657.1 | 625.4 | 592.6 | 608.3 |

*Source: County Health Status Profiles 2020-2024.*

**Table 5: Sacramento County Age-Adjusted Death Rates, 2020-2022 (RY 2024)**

| INDICATOR | 2020-2022 (RY 2024) | | | 2017-2019 Sac Rate |
|---|---|---|---|---|
| | Sac Rank | Sac Rate | CA Rate | |
| ALL CAUSES | 33 | 785.2 | 670.0 | 710.5* |
| ALL CANCERS | 46 | 145.2 | 122.0 | 154.0 |
| COLORECTAL CANCER | 50 | 14.2 | 11.5 | 13.6 |
| LUNG CANCER | 39 | 25.6 | 20.6 | 30.8 |
| FEMALE BREAST CANCER | 44 | 20.0 | 17.6 | 21.2 |
| PROSTATE CANCER | 49 | 22.8 | 18.2 | 22.4 |
| DIABETES | 44 | 28.4 | 23.6 | 28.8 |
| ALZHEIMER'S DISEASE | 54 | 47.4 | 35.5 | 50.2 |
| CORONARY HEART DISEASE | 30 | 78.3 | 77.2 | 93.3 |
| STROKE | 54 | 51.0 | 37.0 | 45.3 |
| INFLUENZA/PNEUMONIA | 32 | 10.8 | 10.9 | 15.3 |
| CHRONIC LOWER RESP.DIS. | 27 | 28.6 | 24.5 | 38.1 |
| CHRONIC LIVER DIS. AND CIRRHOSIS | 22 | 14.8 | 14.4 | 12.6 |
| ACCIDENTS | 25 | 56.2 | 47.9 | 42.6 |
| MOTOR VEHICLE TRAFFIC CRASHES | 25 | 13.8 | 11.5 | 11.4 |
| SUICIDE | 32 | 11.9 | 10.1 | 13.4 |
| HOMICIDE | 40 | 7.4 | 6.1 | 5.7 |
| FIREARM RELATED DEATHS | 33 | 10.7 | 8.7 | 9.3 |
| DRUG OVERDOSE DEATHS | 32 | 27.6 | 25.3 | 16.8 |

*Source: County Health Status Profile 2024, CHSP 2024 Tables 1–29 (Excel), CHSP 2023 Table 30 (Excel).*

*This figure was pulled from County Health Status Profile 2021.

One factor…

Sacramento residents with MediCal benefits do not always have adequate & timely access to Specialty Care

- Health system specialists do not *generally** accept MediCal referrals
- In 2019, 20% of Specialists are unaffiliated – even smaller % accept MediCal … yet 25.5% of the population had Medi-Cal

**TABLE 8. Physicians in Practice Owned by a Hospital or Health System**
Sacramento Area vs. California, 2019

| | Primary Care Physicians | Specialists |
|---|---|---|
| Sacramento Area | 70% | 80% |
| California | 43% | 53% |

Note: Specialty care physicians include physicians practicing cardiology, hematology/oncology, orthopedics, and radiology.

Source: Blue Sky Consulting Group calculation of population-weighted regional and state averages from Richard M. Scheffler, Daniel R. Arnold, and Brent D. Fulton, *The Sky's the Limit: Health Care Prices and Market Consolidation in California*, California Health Care Foundation, October 2019.

**TABLE 2. Trends in Health Insurance, by Coverage Source**
Sacramento Area vs. California, 2015 and 2019

| | SACRAMENTO AREA | | CALIFORNIA | |
|---|---|---|---|---|
| | 2015 | 2019 | 2015 | 2019 |
| Medicare* | 16.3% | 17.8% | 14.4% | 15.9% |
| Medi-Cal | 26.9% | 25.5% | 29.1% | 28.7% |
| Private insurance† | 50.8% | 51.4% | 47.8% | 47.7% |
| Uninsured | 5.9% | 5.3% | 8.6% | 7.7% |

*Includes those dually eligible for Medicare and Medi-Cal.

† Includes any other insurance coverage (excluding Medicare and Medi-Cal).

Source: Calculations made by Blue Sky Consulting Group using data from the US Census Bureau, the Centers for Medicare & Medicaid Services, and the California Department of Health Care Services.

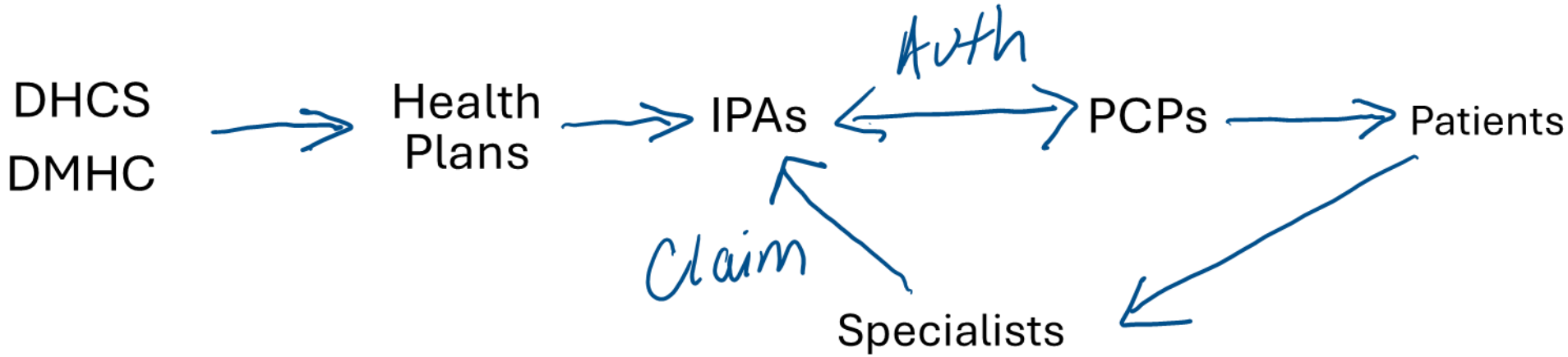
* There are practice specific exceptions

# 1 Patient Example of MANY…

| | | | | | | |
|---|---|---|---|---|---|---|
| 8/5/2025 | [redacted] | Urgent | IPA | Orthopedic Surgery | Hand Fracture | 8/8/2025 - Authorization request initiated.<br>8/11/2025 - Authorization approved and faxed to Stanford.<br>8/14/2025 - Stanford denied referral due to lack of capacity. New auth submitted to insurance.<br>8/19/2025 - Authorization approved and faxed to UCSF.<br>9/3/2025 - New authorization submitted due to UCSF denied referral due to no contract with insurance.<br>9/4/2025 - Authorization approved and faxed to Ortho Surgeon [redacted]<br>9/15/2025 - OCH spoke with patient and office denied referral due to not wanting to take case due to delay in treatment. New authorization submitted to insurance.<br>9/16/2025 - IPA called and s/w OCH staff and asked if authorization can be approved to in-network facilities. We educated [redacted] rep and advised that Dr. [redacted] is not taking any distal radius fractures or hand dx. I also educated that [redacted] is not taking any wrist fractures. Per IPA, this will be sent back for review.<br>9/23/2025 - Authorization approved and faxed to Hand Surgery [redacted]<br>9/29/2025 - Since office is on an LOA contract, referral was e-mailed to IPA so they can forward to specialty office.<br>10/2/2025 - Emailed IPA rep to see if there is any update regarding patient's referral.<br>10/3/2025 - Per IPA contracting; referral should not be faxed to office since contract is still pending. Advised to hold off on referring patient until that has been completed on their end as this contract will also require an LOA. Referral on hold |

| Specialty/Sub-Specialty | Access Shortage Severity | Network Status (Portal) | Issues |
|---|---|---|---|
| **GI** | **HIGH** | | |
| Practice A | MEDIUM | In-network | Hospital not contracted with Molina |
| Practice B | HIGH | In-network | Office not responsive |
| Practice C | HIGH | In-network | Virtual service only |
| Practice D | HIGH | In-network | Don't accept out-of-county (so all our Sacramento area patients have no access) |
| Practice E | MEDIUM | Out-of-network | Contracted providers do not treat liver dx. |
| **Neurology** | **MEDIUM** | | |
| Practice A | HIGH | In-network | Virtual service only |
| Practice B | HIGH | In-network | Office not responsive |
| Practice C | MEDIUM | In-network | Responsive, but referral acceptance criteria is restrictive |
| Practice D | LOW | In-network | |
| Practice E | HIGH | In-network | No longer accepting patients |
| Practice F | HIGH | In-network | Located out of county and only accepts Sacramento referrals on case-by-case basis. |
| **Urology** | **HIGH** | | |
| Practice A | HIGH | In-network | Virtual service only |
| Practice B | HIGH | In-network | Office not responsive, and referral acceptance criteria is very restrictive. |
| Practice C | HIGH | In-network | Office not responsive, and referral acceptance criteria is very restrictive. Only 1 clinician. |
| Practice D | LOW | Out-of-network | |
| **Orthopedic Surgery - Hand** | **HIGH** | | |
| Practice A | HIGH | In-network | Listed under plastic surgery (does some hand surgery) |
| Practice B | HIGH | In-network | New to the network. Promising new access but there is a backlog. |
| Practice C | HIGH | In-network | Only accepts elbow surgery (no hand or wrist). |
| **ENT** | **HIGH** | | |
| Practice A | HIGH | In-network | Responsive, but backlog is severe. |
| Practice B | HIGH | In-network | Virtual service only |
| Practice C | HIGH | In-network | Poor patient experience feedback; no longer sending referrals here |
| Practice D | MEDIUM | Out-of-network | |
| **Speech Therapy** | **MEDIUM** | | |
| Practice A | HIGH | In-network | Nothing available for peds; only 1 location available for adults. |
| Practice B | HIGH | In-network | At capacity for both peds and adults, no access. |
| Practice C | LOW | In-network | Only a peds facility. |
| Practice D | LOW | In-network | Responsive and have access, but virtual service only. |
| Practice E | LOW | In-network | Responsive and have access, but virtual service only. |
| **Rheumatology** | **HIGH** | | |
| Practice A | HIGH | In-network | Virtual service only |
| Practice B | MEDIUM | In-network | Clinic has access, but is located out of county |
| Practice C | HIGH | In-network | Not accepting referrals |
| Practice D | LOW | Out-of-network | |
| Practice E | HIGH | In-network | Not accepting new patients. |

# “Normal” Referral Pathway



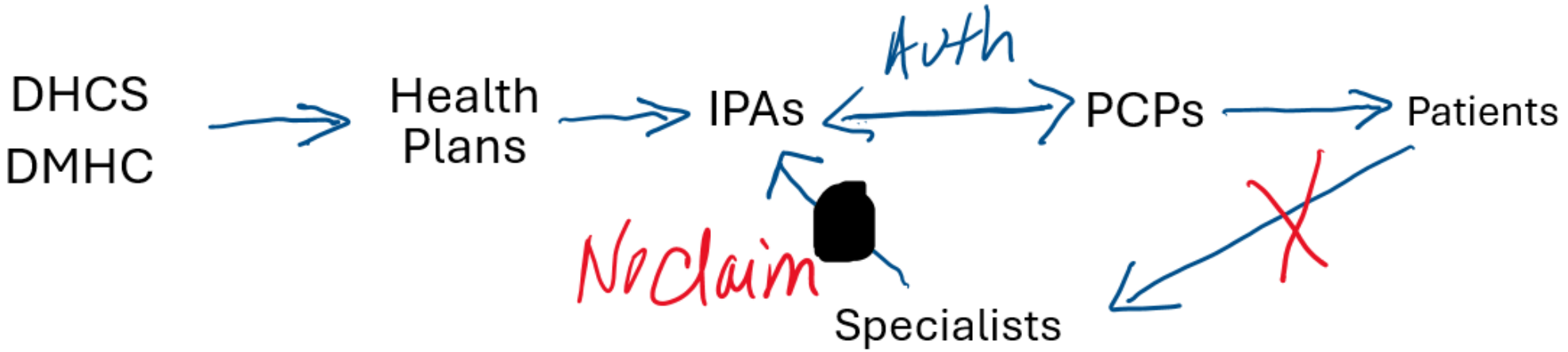

How do the Health Plans & DHCS measure?

Claims, network adequacy audits & grievances

# The “Black Hole” of Data

Claims data measures utilization of visits, diagnoses and procedures… this excludes services that did not happen:

- Referrals are approved, then specialist visit is delayed, or doesn’t happen



# How can we better understand?

1. Authorization data exists
    - Authorization Denial rates
    - Authorizations never completed
    - Days to from Authorization Submitted (or Approved) to 1st appointment with Specialist
    - Specialist utilization % by County (patients being sent to other counties)
2. Health Authority to review and discuss death/disease prevalence rates
3. What else?

NORC at the University of Chicago

# Sacramento County Health Authority General Meeting

## Measuring Specialty Care Access: Options

02.19.2026

**Lisa Shugarman**

# Overview

01 Measurement Options

# Measurement Options

NORC at the University of Chicago

# Data Sources to Measure Specialty Care Access: **Claims Data**

- **Claims data provide details on service utilization, provider involvement, and timing of care events within the Medi-Cal population without requiring clinical detail.**
  - Research Questions that can be answered using only claims data include:
    - Which clinicians provide the majority of specialty care services for the Sacramento County Medi-Cal population?
    - What is the median time interval between primary care visit claims with first evidence of a sentinel condition and subsequent specialty procedure claims for sentinel conditions among Sacramento Medi-Cal patients?
    - What percentage of patients with claims for sentinel requiring specialty follow-up lack subsequent specialty care claims within an expected follow-up period?
- **Depending on the data sources available comparisons to other CA counties or commercial data may be possible.**

# Data Sources to Measure Specialty Care Access: **EHR Data**

- **EHR data adds detailed clinical context, including referral orders, diagnostic information, and provider notes that are not captured in claims data..**
  - Research Questions that can be answered using EHR data in combination with claims data include:
    - How do clinical referral orders documented in EHRs compare with claims data for completed specialty visits, and what proportion of referrals do not result in billed specialist care?
    - How do documented social determinants of health in EHR social history or screening tools relate to observed referral completion and specialty care utilization in claims?
    - For conditions requiring specialist follow-up, what proportion of patients have documented clinical follow-up visits or monitoring in EHRs absent from claims data, revealing gaps in billing or service capture?

# Data Sources to Measure Specialty Care Access: **Qualitative Data**

- **Qualitative data, such as survey or focus group data, can provide insight into patient and provider experiences that are not observable through claims or EHR data.**
  - Research Questions that can be answered using qualitative data include:
    - How do patients describe their experiences with referral processes and wait times for specialty appointments?
    - What challenges do specialists encounter in accepting and providing timely care to Medi-Cal patients?
    - What factors influence Medi-Cal patients' decisions or ability to complete or not complete specialist referrals?
    - How do providers view the impact of administrative and prior authorization requirements on specialty care delivery?

# Discussion

NORC at the University of Chicago

# Agenda Item 8: Public Comment

# Agenda Item 9: Closing Comments & Adjournment